Department of Labor & Industries
PO Box 44291
Olympia WA 98504-4291

Please return this form to L&I at the address above for state fund claims
OR mail it directly to the self-insured company for self-insured claims.

OPIOID PROGRESS REPORT SUPPLEMENT: CHRONIC, NONCANCER PAIN

Patients's name	Today's date	Patient's signature	L&I Claim #

Billing instructions: When prescribing opioids for chronic, noncancer pain; the attending physician must submit this form, or a substantially equivalent form at least every 60 days. Providers are encouraged to submit this form after each visit. The provider must use code 1057M to be reimbursed for the completion of this form.
For more information: The complete rules and guidelines on this topic can be found on the Internet at www.lni.wa.gov/omd/opioids

SECTION 1 - Patient's Portion:

1. On average, how severe was the pain this last week? (circle number)
0 = no pain 10 = worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2. How many hours did you work:
Last week? The week before?

3. What activities at home or work are difficult for you because of pain? For example: sitting, standing, walking, reaching over head, climbing stairs.
Activity #1_____ #2_____ #3_____

Describe any change in these 3 activities since the last medical visit. Be specific (For example: "Can walk 8 blocks now. The last time I saw Dr. Smith, could only walk one block.")

Activity 1 _____

Activity 2 _____

Activity 3 _____

SECTION 2 - Doctor's Portion:

4. For what diagnosis are you prescribing opioids?

5. Current medications and dosages (including new prescriptions)

6. Please estimate your patient's level of function. (To answer this question, consider all data deemed relevant. This might include information that is self-reported, such as patient response to #3 or from another observer such as direct examination by a physician or through a physical capacities examination by a physical therapist.)

* **If this is the beginning of the opioid trial, skip 6(a).** 6(b) will establish a baseline from which improvement will be measured.

(a) Functional level at last visit _____ Date of last visit ____/_____/_____

(b) Functional level at this visit (circle your numerical estimate)

0 = severe impact on function at home or at work 10 = returned to level of function prior to injury
0 1 2 3 4 5 6 7 8 9 10

7. Has there been overall improvement in the patient's pain and function since opioids were first used to treat the patient's chronic pain, in terms of daily living or work activities? (check one box)

☐ Yes
☐ No. Opioids will be discontinued, see my treatment plan below.
☐ No. A consultation has been scheduled for / /
☐ No. See modified treatment plan in question #8.
☐ No. Patient has reached maximum medical improvement
I will rate PPD ☐ Please schedule an IME ☐

8. What is your medical treatment plan to improve the patient's function? If the patient is not working, specifically address the activities that prevent the worker from participating in return to work efforts (e.g., light duty, retraining). What is the timeline?
(If you need more space, please continue in your SOAPER note.)

9. Have any consultations been scheduled? ☐ Yes ☐ No Date of consultation: / / Name of Consultant:

10. Is there any concern about misuse of medications? ☐ Yes ☐ No
Is there any concern about ☐ tolerance ☐ dependence ☐ toxicity? (Check all that apply. Provide details in your SOAPER note.)

11. Has six months passed since you and your patient last signed the treatment agreement? ☐ Yes ☐ No.
If yes, you and your patient must re-sign the treatment agreement and attach to this form.

Physician name (please print)	Date	Physician signature
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